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No. _____

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In The

Supreme Court of the United States

October Term, 1993

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; TEAMSTERS LOCAL 11 BENEFIT PLAN; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; THE TRUSTEES OF THE LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; LOCAL 464A UNITED FOOD AND COMMERCIAL WORKERS UNION GROUP REIMBURSEMENT WELFARE FUND; and LOCAL 945 IBT WELFARE FUND,

Petitioners,

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON, in his capacity as New Jersey Commissioner of Health; et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Is health care regulation by a state exempt from the Employee Retirement Income Security Act's ("ERISA") preemption clause based upon a "traditional state police power," as the Third Circuit Court of Appeals concludes, or should Congress' mandate and this Court's precedent regarding the broad scope of ERISA's preemption be reaffirmed?

2. Did the Third Circuit Court of Appeals ignore this Court's ERISA preemption standard when it determined that a health care statute did not "relate to" ERISA even though the statute shifted a disproportionate share of the cost of hospital care for the indigent onto ERISA participants who, comprising only 15% of the hospital users, were forced to pay for 40% of the uncompensated care costs in New Jersey?

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the Third Circuit Court of Appeals Decision which is contained in the Appendix at 1a-5a. Because of the numerosity of the parties, the list will not be reproduced herein.

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Petitioners United Wire, Metal & Machine Health and Welfare Fund, the Operating Engineers Local 825 Welfare Fund, Teamsters Local 11 Benefit Plan, Trustees of the Teamsters Local 11 Benefit Plan, Local 807 Labor-Management Health Fund; The Trustees of the Local 807 Labor-Management Health Fund; The Trustees of the

Local 807 Labor-Management Health Fund, Local 464A United Food and Commercial Workers Union Group Reimbursement Welfare Fund, and Local 945 IBT Welfare Fund (the "Welfare Funds") respectfully petition for a writ of certiorari to review the judgment of the United State Court of Appeals for the Third Circuit entered on May 14, 1993.

OPINIONS BELOW

The Order of the Court of Appeals for the Third Circuit, for which review is sought, is unofficially reported at 61 U.S.L.W. 2723 (3d Cir. May 14, 1993) and is reprinted in the Appendix.[1] (1a) The decision of the United State District Court for the District of New Jersey is reported at 793 F. Supp. 524 (D.N.J. 1992) and is reproduced for the Court's convenience in the appendix. (64a). Additionally, the unreported order of the Court of Appeals denying a rehearing is contained in the appendix. (62a)

[1] The Welfare Funds respectfully rely upon the Appendix already submitted by petitioner NYSA-ILA Welfare Fund under Docket No. 93-115, which was filed with the Supreme Court on July 22, 1993. All cites to the Appendix in this petition for Certiorari shall refer to this Appendix and shall hereinafter be abbreviated (___a).

JURISDICTION

Judgment was entered by the Court of Appeals for the Third Circuit on May 14, 1993. On July 8, 1993, the Court of Appeals granted Petitioner's Motion for Stay of Mandate, which stay was extended until August 6, 1993 by further Order dated July 16, 1993. This Court has jurisdiction pursuant to 28 U.S.C. 1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

1. The Supremacy Clause of the United States Constitution, U.S. Const., Art. VI. cl. 2., provides in relevant part:

> "This Constitution, and the Laws of the United States which shall be made in pursuance thereof . . . shall be the supreme Law of the Land . . . , any Thing in the Constitution of Laws of any State to the Contrary notwithstanding."

2. The relevant statutory provisions of ERISA are as follows:

(a) ERISA's preemption clause is contained in Section 514(a), 29 U.S.C. § 1144(a) which provides:

> except as provided in subsection (b) of this section, [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b).

(b) ERISA, 29 U.S.C. § 1103(c)(1):

> the assets of a plan . . . shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries . . .

STATEMENT OF THE CASE

This is a petition for certiorari to review a judgment of the United States Court of Appeals for the Third Circuit. As described below, this action involves a challenge under ERISA's preemption provision to three surcharges levied on hospital users pursuant to the New Jersey hospital rate setting scheme. These surcharges are designed to disproportionately syphon money from ERISA welfare funds to pay for a state mandated social program to subsidize the cost of health care for the indigent. On petitioners' motion for summary judgment in the District Court the rate setting scheme was declared preempted by ERISA.[2] This ruling was reversed on appeal by the Third Circuit Court of Appeals by a 2-1 majority.

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[2] On January 1, 1993, the hospital billing scheme in New Jersey was replaced with a new system. Although the specific billing scheme as challenged has been abandoned, the questions presented on this petition remain significant and, as the Third Circuit recognized, certainly are not moot. In addition to large monetary claims between the Welfare Funds and hospitals in this action, the decision has wide-spread implications on the structure of hospital billing schemes nationwide. Several other states have existing health care systems, similar to that challenged herein. Consequently, this Court's consideration of the present petition will determine whether hospital rate regulation can continue to be structured nationwide to extract from ERISA funds a disproportionate share of our country's health care bill.

The Challenged Rate Setting Scheme

The New Jersey hospital rate setting scheme was established pursuant to the New Jersey Health Care Facilities Planning Act (the "Planning Act"), as amended and supplemented by the Health Care Cost Reduction Act (the "Reduction Act"), N.J.S.A. 26:2H-1 *et seq.* (collectively, the "Act"), as well as the regulations promulgated thereunder, N.J.A.C. 8:31B *et seq.* Pursuant to the rate setting scheme, patients in New Jersey receive hospital bills based upon a categorization into Diagnostic Related Groups ("DRG"). The DRG billing rate is selected by the hospital based upon a clinical categorization of a patient's illness and treatment into one of 742 categories of medical conditions. In accordance with procedures and rates established by the State, each DRG category is assigned a hospital specific dollar amount, based upon the specific hospital's costs as well as statewide averages, which the hospital is required to charge regardless of whether the actual medical costs incurred in treatment of the patient are above or below the DRG rate. The DRG base cost encompasses a wide variety of direct and indirect patient costs, including employee salaries, and institutional overhead expenses for management, educational, research and maintenance functions.

Although originally intended as such, the DRG charge is no longer simply a weighted average of expected medical costs for a given condition. The weighted average component is merely the base cost upon which surcharges are added to arrive at the actual DRG rate charged to a patient. Surcharges or "add-ons" are included in the DRG rate as follows: (1) a 19.1% surcharge to pay for uncompensated care to the indigent

and poor; (2) a 7% surcharge to compensate hospitals for a shortfall provided by the federal Medicare program; and (3) a maximum 11% payor differential added to counter-balance the discounts granted to certain classes of payors, such as Blue Cross. Each of these surcharges is designed to raise funds to pay for care for the poor. The Welfare Funds do not challenge the base DRG system, but rather the specific surcharges included therein.

The Uncompensated Care Surcharge

Hospitals in New Jersey are prohibited by state statute from denying admission to patients on the basis of their ability to pay and are required to treat every patient who seeks treatment. To compensate hospitals for their required treatment of the indigent and uninsured, referred to as "uncompensated care", a 19.1% surcharge is added to the DRG base cost on each patient's bill. This uncompensated care add-on is collected by each hospital and forwarded to the New Jersey Health Care Trust Fund, which fund then redistributes the money to hospitals state-wide based upon the amount of uncompensated care costs incurred by each individual hospital.[3]

The Medicare Cost Shift

In addition to the uncompensated care add-on, each hospital bill includes a 7% add-on to compensate

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[3] These funds are also used by the State to obtain matching federal funds, which, rather than being used to offset health care, are placed into the State's general treasury to pay for other expenses of government.

hospitals for the "Medicare cost shift." Under the federal Medicare program, hospitals are reimbursed by the federal government for services provided to Medicare patients. However, pursuant to the administration of the Medicare program, New Jersey hospitals are reimbursed for the care provided at a lower rate than the New Jersey DRG rate. Thus, included in the DRG rate is a "Medicare cost shift" that forces other hospital payors to underwrite the shortfall between the DRG rate and the rate of reimbursement from Medicare.

The Payor Differentials

The third cost-shifting mechanism under the DRG rate system involves "payor differentials", or discounts in payment rates available to certain favored classes of payors. These discounts are offered to select payors who demonstrate "quantifiable economic benefit" to the health care system, such as Blue Cross, Blue Shield and health maintenance organizations. For example, Blue Cross receives an 11% discount because of its open enrollment policy. Due to restrictions imposed by ERISA, the Welfare Funds must limit their enrollment and cannot receive this same discount, even though the ERISA plans provide open enrollment within the category of workers and their families eligible to participate in their plans. Discounts have been granted to all classes of payors except commercial insurers and self-funded payors such as the Welfare Funds. As a result of the discounts offered to certain payors, a surcharge is levied on the remaining payors to offset revenue losses generated by the payor discounts. Thus, the Welfare Funds must pay higher fees in order to make up for the discounts offered to others.

The Impact Of the Hospital Billing Scheme on ERISA Plans

These surcharges were implemented by the State in an effort to pay for the growing cost of uncompensated medical care, which costs have increased from a level of $288 million in 1983 to in excess of $700 million dollars in 1990. In New Jersey alone, ERISA participants who comprise 15% of the hospital patients each year are required to pay 40% of the current $1.1 billion dollars of state-mandated cost shifts. This $450 million dollar charge against ERISA funds and their participants reflects one year's burden alone. These surcharges, characterized in the Report of the Governor's Commission on Health Care Costs as a tax to subsidize a social program, increase the average hospital bill charged to ERISA plan participants in New Jersey by approximately 37%. As noted by Judge Nygaard in his dissenting opinion, these surcharges are specifically designed by the State to syphon ERISA plan funds to subsidize non-ERISA fund hospital patients.

The District Court's Decision

Plaintiff/Petitioner United Wire filed its complaint on July 3, 1990. Several other welfare funds then filed similar complaints which were all consolidated. Defendant, the State of New Jersey (the "State"), and intervenor defendant, the New Jersey Hospital Association (the "Hospital Association") moved to dismiss the complaints under Fed. R. Civ. P. 12(c); the Welfare Funds cross-moved for summary judgment.

By Order dated May 27, 1992, and clarified by Order dated June 4, 1992, the District Court granted summary judgment to the Welfare Funds and granted permanent injunctive relief barring the prospective enforcement of the challenged statutory and regulatory provisions. In its opinion the District Court found several bases for ERISA preemption under the "relate to" test established by the Supreme Court, holding that the statutes and regulations had both direct "references to" ERISA plans and had a "connection with" such plans. The Court specifically found that the hospital billing scheme forced the Welfare Funds to structure their benefits in a particular manner; interfered with the Welfare Funds purpose by preventing them from providing full coverage of hospital bills; subjected the funds to inconsistent state regulation; interfered with the administration of fund benefits; forced the funds to incur substantial costs for the benefit of non-members in direct violation of ERISA; interfered with the relations among the principal ERISA entities; interfered with the calculation of plan benefits; and interfered with a participant's right to appeal a bill by mere virtue of his membership in the plan. The District Court declined to exercise jurisdiction over the Welfare Funds' claims for reimbursement of hospital bills paid under protest, saying that these common law claims belonged in State court.

The Third Circuit's Decision

The State Hospital Association and various individual defendant hospitals filed notices of appeal. The Welfare Funds cross-appealed challenging the District Court's refusal to exercise jurisdiction over the

claims for reimbursement of hospital bills paid under protest during the pendency of the lawsuit.

In a 2-1 split decision, the United States Court of Appeals for the Third Circuit reversed the District Court's decision and entered judgment in favor of respondents. The majority relied upon a purported exemption to ERISA preemption for state statutes dealing with "traditional state police powers" and concluded that, despite the substantial economic impact the scheme had on ERISA plans and despite the enormous diversion of plan resources from the intended ERISA beneficiaries, the statute had only a "tenuous, remote or peripheral" effect on the Welfare Funds. Having reversed the District Court, the Third Circuit never addressed the Welfare Funds' claims for reimbursement of bills paid under protest during the litigation. If the Supreme Court grants this petition and reverses the Third Circuit, it should remand the reimbursement issue for further consideration.

A WRIT OF CERTIORARI SHOULD ISSUE BECAUSE THE THIRD CIRCUIT'S DECISION CONFLICTS WITH ERISA'S BROAD PREEMPTION CLAUSE AND WITH THE SUPREME COURT'S PREEMPTION STANDARD

I. The Expansive Scope of ERISA's Preemption Clause

The Supremacy Clause of the United States Constitution provides that "the Laws of the United States shall be the supreme Law of the Land." U.S. Const., Art. VI. cl. 2. Under the preemption doctrine attendant to the Supremacy Clause, a state law must give way to

Congressionally enacted statutes where the state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941); *U.S.A. Chamber of Commerce v. State*, 89 N.J. 131, 142 (1982). "Preemption may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." *FMC Corp. v. Holliday*, 498 U.S. 52, 56-57 (1990); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983); *Fidelity Fed. S & L Ass'n v. De La Cuesta*, 458 U.S. 141, 152-53 (1982); *Jones v. Rath Packing Co.*, 430 U.S. 519, 525, *reh. denied*, 431 U.S. 925 (1977).

ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans. *Shaw*, 463 U.S. at 90. To this end, ERISA contains a broad preemption provision in Section 514(a), 29 U.S.C. § 1144(a) that provides:

> except as provided in subsection (b) of this section, [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b).

29 U.S.C. § 1144(a).

The United States Supreme Court has determined consistently that Congress expressly provided a "broadly worded preemption provision in a comprehensive statute," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) which "is conspicuous for its breadth," *FMC Corp.*, 498 U.S. at 58. As discussed by the Supreme Court, the legislative history supports an expansive construction of

ERISA's preemptive effect. *Shaw*, 463 U.S. at 98-99, n.20; *FMC Corp.*, 498 U.S. at 58-59.

The key to interpreting the breadth of ERISA's preemption clause are the words "relate to."

> Congress used those words in their broad sense, rejecting more limited preemption language that would have made the clause 'applicable only to state laws relating to the specific subjects covered by ERISA.'

Ingersoll-Rand, 498 U.S. at 138 (quoting *Shaw, supra*, at 98).[4] With regard to this broad intent, the Supreme Court has defined the phrase "relate to" in the context of the ERISA's preemption clause by stating:

> A law *relates to* an employee benefit plan . . . if it has a connection with or reference to such a plan.

Shaw, 463 U.S. at 96-97.

> Under this "broad common sense meaning," a state law may "relate to" a benefit plan, and thereby be preempted, *even if the law is not specifically designated to affect such plans, or the effect is only indirect.*

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[4] To further enhance the preemption clause's broad scope, the terms "State law" and "State" were broadly defined. With respect to ERISA's preemption clause, the term "State law" includes "all laws, decisions, rules, regulations or other State action having the effect of law, of any State." ERISA Section 514(c)(1), 29 U.S.C. § 1144(c)(1). The term "State" includes "a State . . . or any agency or instrumentality . . . which purports to regulate, *directly or indirectly, the terms and conditions* of employee benefit plans covered by this title." ERISA Section 514 (c)(2), 29 U.S.C. § 1144(c)(2) (emphasis supplied).

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (emphasis added). See *Ingersoll-Rand*, 498 U.S. at 138-139; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); *Shaw*, 463 U.S. at 98. ERISA's preemption clause distinctly applies to state laws dealing with matters not themselves covered under the ERISA statute, *FMC Corp.*, 498 U.S. at 58-59; *Ingersoll-Rand*, 498 U.S. at 138, and even if the state law is "consistent with ERISA's substantive requirements," *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), or if the law was enacted to "effectuate ERISA's underlying intent." *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988).

In its two most recent decisions addressing preemption under ERISA, the Supreme Court again reiterated its broad and expansive reading of ERISA's preemption clause. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), a self-funded health care plan, after paying a portion of the participant's medical expenses stemming from an automobile accident, attempted to recover its expenses pursuant to a subrogation clause contained in its plan from a participant who had recovered damages in a negligence action relating to the accident. Pennsylvania's statutory law contained a provision prohibiting recovery by any program, group contract or other arrangement upon any subrogation rights. Under the "relate to" test, the Supreme Court struck down the Pennsylvania law on preemption grounds because the law had a specific "reference to" ERISA plans contained in its language and additionally a "connection with" such plans. In evaluating the laws "connection with" the benefit plan the Supreme Court stated:

> Pennsylvania's antisubrogation law prohibits plans from being structured in a manner

> requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ[ed] from those in states that [had] not enacted similar antisubrogation legislation. Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide.

FMC Corp., 498 U.S. at 60.

In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Supreme Court addressed whether ERISA's explicit language and purpose preempted a state common law cause of action by an employee who was wrongfully discharged to prevent his attainment of benefits under an ERISA covered plan. In striking down such a cause of action, the Court noted:

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefit law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries. Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose . . . . Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards

> applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement. (Citations omitted).

Id. at 141. *See also Shaw*, 463 U.S. at 105 and n. 25.[5] Thus, it is overwhelmingly clear that ERISA was designed to establish the regulation and administration of ERISA benefit funds as *exclusively* a federal concern.

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[5] In addition to the Supreme Court's reiteration of a vastly broad ERISA preemption test, numerous cases have expounded upon the expansive nature or this preemptive clause. In analyzing whether a statute has a "connection with" ERISA benefits plans, Courts will seek to ensure that substantive benefits not be subject to the ambiguities of state law. *PPG Indus. Pension Plan A (CIO) v. Crews*, 902 F.2d 1148, 1151 (4th Cir. 1990). ERISA forbids a result whereby a subject plan will apply differently to otherwise identically situated beneficiaries who live in different states under different statutory regimes. *Id. See also Local Union 598 v. J.A. Jones Const. Co.*, 846 F.2d 1213, 1219 (9th Cir. 1988). Also forbidden are attempts to prescribe either the type or amount of an employer's contribution; the rules and regulations under which a plan operates; or the nature or amount of the benefits provided thereunder. *General Electric v. Dept. of Labor*, 891 F.2d 25, 29 (2d Cir. 1989), *cert. denied*, 496 U.S. 912 (1990) (amount of contribution); *Local Union 598*, 846 F.2d at 1219 (amount of contribution); *Stone v. Webster Eng'g Corp.*, 690 F.2d 323, 329 (2d Cir. 1982), *aff'd sum. sub nom, Arcudi v. Stone and Webster Eng'g Corp.*, 463 U.S. 1220 (1983) (amount of contribution); *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294, 1297-1300 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.) (*per curiam*), *cert. denied*, 439 U.S. 831 (1978) (rules under which plan operates); *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 706-07 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd sum.*, 454 U.S. 801 (1981) (nature or amount of benefits).

II. ERISA's Preemption Clause Applies To State Health Care Regulation

The expansive scope of ERISA preemption applies to state health care regulation. Time after time the courts have had to curtail state health care regulations that have infringed upon ERISA welfare funds. A solid line of precedent exists, particularly when states have sought to extract money from ERISA funds to pay for social programs. *See The Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), *appeal pending*, Docket No. 93-7132 (2d Cir. 1993) (surcharges applied to hospital bills were preempted because of the substantial economic impact the surcharges had on ERISA plans and the diversion of plan resources from the intended ERISA beneficiaries); *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771 (E.D. La. 1991) (two dollar surcharge on hospital bills to fund the administration of a catastrophic health insurance program was preempted by ERISA); *United Health Services, Inc. v. Upstate Administrative Services*, 573 N.Y.S.2d 851, 14 E.B.C. 1301 (N.Y.S. Sup. Broome Cty. 1991) (invalidating aspects of New York State DRG system); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991) (finding tax on benefits received to be preempted).[6]

These cases illustrate that ERISA welfare funds cannot be unduly burdened, either economically or

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[6] Additionally, in 1982, Congress amended ERISA's preemption provision to exempt the Hawaii Prepaid Health Care Act. 29 U.S.C. § 1144(b)(5)(B)(i). This limited amendment shows that the scope of ERISA preemption was intended to affect health care funding.

administratively, by particular state attempts at health care regulation. A state may regulate health care, but it may not force ERISA funds to jeopardize their well-being by supporting programs for those who have not contributed to the ERISA fund. Petitioners' challenge in this action follows this simple, straightforward rationale, which compels a conclusion that the New Jersey hospital scheme is likewise preempted.

For reasons unknown, the Third Circuit chose to ignore the solid precedent that should have led to the preemption of the hospital surcharges against the Welfare Funds. The Court speculated that Congress did not intend ERISA preemption to extend to the regulation of health care costs. As stated by the majority:

> In short, we are unwilling to attribute to Congress and [ERISA's preemption clause] an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged.

(31a-32a).

Faced with no support from Congress for its position and a wave of cases against it, the majority resorted to the single 1984 case of *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), which upheld a New York statute prohibiting ERISA funds from negotiating discount rates with hospitals. The *Rebaldo* decision, which predates many of the Supreme Court's recent ERISA preemption cases, relies upon a purported

preemption exception for state laws dealing with areas of "traditional state police power." As discussed below, the *Rebaldo* decision is not in accord with the current state of the law.

The underlying rationale of *Rebaldo* has been expressly overruled. As acknowledged by the majority, *Rebaldo* used a narrow formulation of the "relate to" clause in ERISA – holding preemption occurred only where the statute directly "affect[ed] the structure, administration, or the type of benefits provided by an ERISA plan." *Id.* at 139. (28a-30a) This restrictive approach to ERISA preemption was expressly overruled in *Ingersoll-Rand*, 498 U.S. at 141-142. *See also General Motors Corp. v. Caldwell*, 647 F. Supp. 585, 588 (N.D.Ga. 1986); *United Health Services*, 573 N.Y.S. 2d at 854-855.

In addition, *Rebaldo*'s holding that health care regulation is exempted from ERISA's preemption clause as a "traditional state police power" has been expressly rejected in subsequent preemption decisions. As recently explained in *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341, 1350 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992):

> We reject St. Mary's argument that preemption is not appropriate because the assignment statute is an exercise of traditional state power. Like the Fifth Circuit we are "not convinced that . . . the traditional or nontraditional nature of the state law . . . properly bears upon the question whether a state law of general application affects a benefit plan in so tenuous, remote, or peripheral a way that it cannot be said to 'relate to' the plan." Although the Supreme Court has not discussed the relevance

> of this factor, its failure to consider this criterion when deciding ERISA preemption cases is telling. *See FMC Corp v. Holliday*, ___ U.S. ___, 111 S. Ct. 403, 112 L.Ed.2d 356 (1990); *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825 (1988) (state garnishment law).

This "traditional state power" rationale has never been utilized as a relevant factor by the Supreme Court and has been rejected or ignored in several recent ERISA preemption challenges expressly dealing with surcharges imposed upon hospital bills. *See The Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), appeal pending, Docket No. 93-7132 (2d Cir. 1993); *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771, 14 E.B.C. 1529 (E.D. La. 1991); *United Health Services, Inc. v. Upstate Administrative Services*, 573 N.Y.S.2d 851, 14 E.B.C. 1301 (N.Y.S. Sup. Broome Cty. 1991). Notably, even the Second Circuit, author of the *Rebaldo* decision, has abandoned its prior decision. *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 n.3 (2d Cir. 1992).

Health care reform is a pressing issue in the 1990's and states will increasingly experiment with solutions to the health care crisis. This experimentation, nevertheless, must remain within parameters that do not unfairly and disproportionately burden ERISA welfare funds. By creating an outright exception to the ERISA preemption doctrine for health care regulation, the Third Circuit Court of Appeals has given states an open invitation to extract money from ERISA funds to subsidize the cost of health care for all segments of society.

In New Jersey alone in 1992 some $450 million was diverted from ERISA funds to subsidize the cost of

medical care for non-ERISA beneficiaries. (37a) When the Court considers that more than 30 states either have existing or pending legislation enacting systems similar to New Jersey's. 138 Cong. Rec. S13267-02 (Sept. 10, 1992). It becomes obvious that the nationwide financial impact of the Third Circuit's decision will undermine every purpose that Congress sought to achieve in enacting ERISA. A pandora's box of state regulations will open to tap ERISA funds as a means to pay for social programs for non-ERISA participants. As aptly stated by Judge Nygaard in his dissenting opinion:

> I fear that the majority gives States free reign to spend and experiment with ERISA funds, held in trust for the many workers who have labored long for their security, in noble pursuit of health care reforms so long as States exercise a minimum degree of imagination by couching their statutes in "generally applicable" terms.

(43a-44a)

In short, the decision by the Third Circuit cannot be what Congress intended. If left to stand, the result will be a plethora of new legislation (followed by more litigation) targeted to extract from ERISA funds a disproportionate share of our country's health care bill and the undermining, if not possible collapse, of the ERISA welfare fund system.

III. The New Jersey Hospital Billing Scheme "Relates To" ERISA Welfare Funds And Has More Than A "Tenuous, Remote Or Peripheral" Effect On The Welfare Funds[7]

There is no doubt that the challenged surcharges have an enormous financial impact upon the Welfare Funds. In fact, the enormous financial role played by ERISA funds in the New Jersey hospital funding scheme is best exemplified by the State of New Jersey's admission that "the scheme is not 'viable' without money from the plans." (35a) It is impossible to argue logically, given this admission, that the legislation does not "relate to" the ERISA Welfare Funds.

The shear enormity of the surcharges has forced plans to either increase the level of contributions required to meet the participants' welfare needs, reduce the level of benefits available, or deplete the assets of the Welfare Funds. For every dollar paid by the Welfare Funds to subsidize the care of non-participants, the Funds are forced to reduce benefits provided or attempt to pass along the increased costs to its participants, either directly or indirectly through the renegotiation of collective bargaining agreements. Such effect clearly

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[7] Three specific references are contained in the hospital rate setting scheme referring to ERISA welfare plans. Two references are contained in the Patient Appeal Policy. The third reference to such plans is contained in the Act itself. (36a-37a) These references *alone* constitute sufficient basis to find the statute preempted. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987). *See also Ingersoll-Rand*, 498 U.S. at 138-139; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw*, 463 U.S. at 97.

relates to the Welfare Funds. *See In re Morgan Guaranty Trust Co. of N.Y.*, 80 N.Y.2d 44, 52, 599 N.E.2d 656, 661, 587 N.Y.S.2d 252, 257 (N.Y. Ct. of Appeals 1992) (statute of general application which "directly deplete funds otherwise available for providing benefits flies in the face of ERISA's goal of assuring the financial soundness of such plans").

In *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991), *cert. denied*, 112 S. Ct. 585 (1991) a Texas statute which imposed a 2.5% annual tax on ERISA welfare benefit plans was found preempted. The court held that economic impact *alone* was adequate grounds to find a "connection with" such plans. The court noted that the tax:

> reduce[d] future assets and the capability of the plans to pay benefits. The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation.

Id. at 1103. *See also The Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993) (surcharges applied to New York hospital bills were preempted because of the substantial economic impact the surcharges had on ERISA plans and the diversion of plan resources from the intended ERISA beneficiaries); *In re Morgan Guaranty*, 80 N.Y.2d at 51-52; *R.R. Donnelley & Sons Co. v. Provost*, 915 F.2d 787, 791-92 (2d Cir. 1990), *cert. denied*, 111 S. Ct. 1415 (1991) (recognizing preemption based on economic impact).

The impact of these surcharges is more extensive than financial alone. The diversion of ERISA funds to pay for the care of non-ERISA patients stands in direct conflict with the express intent of Congress to protect the interests of participants in employee benefit plans. Pursuant to ERISA, 29 U.S.C. § 1103(c)(1):

> the assets of a plan . . . shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries . . . [8]

Thus, Congress has expressed a clear intent that Welfare Fund moneys be used strictly and exclusively for the benefit of the plans' beneficiaries. Contrary to this express purpose, the surcharges, by both design and effect, divert ERISA funds to subsidize and support the cost of medical care for non-plan members. Similar hospital surcharges to subsidize the care of non-participants have been held preempted by ERISA. *See Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F.Supp. 771 (E.D. La. 1991).

Moreover, in addition to reducing funds available for plan beneficiaries, the challenged surcharges have forced the Welfare Funds to alter benefits provided and have interfered with the coordination and administration of interstate benefits. As an example, United Wire's plan

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[8] Additionally, 29 U.S.C. § 186(c)(5) conditions ERISA welfare funds' receipt of contributions from employers on such payments being "held in trust for the purpose of paying, . . . for the benefit of employees, their families and dependents, for medical or hospital care." *See also* 29 U.S.C. §§ 1002, 1103(a) and 1103(c)(i). This provision further limits the use of such funds for the sole and exclusive benefit of the employees of such employer and their families and dependents.

provides full coverage for hospital services provided in states other than New Jersey. However, because of the enormous surcharges imposed in New Jersey, the Fund has been forced to alter its benefits within New Jersey to provide less than full coverage. As a matter of black letter law, ERISA forbids a statutory scheme which forces an ERISA plan to apply differently to otherwise identically situated beneficiaries who live in different states, *PPG Indus.*, 902 F.2d at 1151; *Local Union 598*, 846 F.2d at 1219; *Shaw*, 463 U.S. at n. 20, n. 25, and preempts state laws which interfere with the administration of benefits. *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771 (E.D. La. 1991) (a two dollar surcharge on hospital bills of all insured patients, which surcharge was used to benefit non-members, affected the administration of the plan); *Greater Washington Bd. of Trade v. District of Columbia*, 948 F.2d 1317, 1325 (D.C. Cir. 1991), *aff'd*, 113 S. Ct. 580 (1992); *Birdsong v. Olsen*, 708 F. Supp. 792, 801 (W.D. Tex. 1989).

Based upon the enormity of the economic impact of the challenged surcharges on the Welfare Funds, the administrative burdens imposed upon the Welfare Funds, and the interference created with uniformity of benefits, a conclusion that the New Jersey hospital rate setting scheme is preempted by ERISA is inescapable.

CONCLUSION

In light of the broad implications that flow from the incorrect decision by the Third Circuit, it is respectfully requested that this Court grant a Writ of Certiorari.

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Respectfully submitted,

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